#5

November 29, 2002

Cathy A. Blake, Director
Healthcare Quality Initiatives
Office of Health Systems Management
161 Delaware Avenue
Delmar, NY 12054

Ideal Senior
Living Center

Dear Ms. Blake:

Please find enclosed an application with attachments for the 2002 New York State Patient Safety Award. As President and Chief Executive Officer, I am submitting this for Ideal Senior Living Center in Endicott, New York.

Our application reflects the strategies we have implemented since June 2000 to prevent and reduce the prevalence of Pressure Ulcers in our Skilled Nursing Facility.

If you have any additional questions, please feel free to call me at (607) 786-7308.

Thank you for providing us with the opportunity to submit this application. I look forward to your response.

Sincerely,

Maria Motsavage

Maria Motsavage
President, CEO, Administrator

508 High Avenue
Endicott, New York 13760
607.786.7300

2002 New York State Patient Safety Award Application

Submitted by: Ideal Senior Living Center
508 High Avenue
Endicott, NY 13760

Project Title: The Prevention and Reduction of Pressure Ulcers in Long Term Care

Contact person: Maria Motsavage, President/CEO/LNHA
(607) 786-7308

Ideal Senior Living Center is a member of United Health Services Health Care System. Our campus is comprised of a 150 bed Skilled Nursing Facility, (50 bed Alzheimer Unit; 25 bed Rehabilitation Unit; 25 bed "Special Care" unit; and 50 chronic care beds) 47 Adult Home beds, 23 Assisted Living Beds, 33 Independent Apartments, and a Long Term Home Health Care Program / AIDS Home Care Program.

DESCRIPTION OF QUALITY IMPROVEMENT PROGRAM

Our Quality Improvement Program centered around the prevention and reduction of pressure ulcers in residents residing in our Skilled Nursing Facility. In April of 2000, our Nursing team conducted a prevalence study of residents in our Skilled Nursing Facility with pressure ulcers. The rate was 22%. At that time, we structured an interdisciplinary team that included:

*Nursing
*Physical Therapy
*Occupational Therapy
*Registered Dietician
*Enterostomal Therapist (under contract from United Health Services Hospitals)
*Certified Nursing Assistants

This team focused on the steps we would need to implement to reduce our current status of pressure ulcers, and prevent new ones. The first thing they determined was that all residents would be reassessed quarterly and annually, with episodic charting of skin integrity changes, lab chemistry changes and weight changes. Any resident with any status change would be discussed at morning report. The participants at morning report included representatives of all disciplines. This discussion would generate an immediate follow-up to determine if there was an increased risk of development of pressure ulcers as a result of the status change, especially if this change resulted in a reduction of mobility, or jeapardized the nutritional and hydration status of the resident. In addition, any post hospitalization assessment would include a determination of risk for the development of pressure ulcers.

PROTOCOL DEVELOPMENT

Admission guidelines were modified to include skin integrity, determination and appropriate interventions so that preventative care could be immediately initiated. Every week a review of all residents with compromised skin integrity is conducted by nurse team leaders. (The tracking form is Attachment 1) These results are then reviewed with the Director of Nursing, Administrator, Enterostomal Therapist (ET), and the Registered Dietician every two weeks. (Attachment 2) All interventions, equipment, treatments etc. are included. A full summary is reported to the Quality Improvement Committee on a monthly basis, and to the Board of Directors Quality Improvement Committee quarterly.

Every two months, a complete skin assessment is completed on all residents, unless there is a significant change in status sooner than that, as earlier noted.

One of the crucial components to this program is education. In May of 2000, all nurses were inserviced regarding skin care issues. The Enterostomal Therapist educated them on pressure ulcer protocol (Attachment 3, 3A, 3B), with emphasis on prevention and treatment and the proper staging of pressure ulcers. A significant amount of time was spent on documentation, assessment. and referral protocols, i.e. when to notify the Enterostomal Therapist regarding a change in skin integrity. The Enterostomal Therapist is on site here at least 2 days per week, working with staff and assessing residents.

In addition, an annual Wound Care Teaching day was established in 2000 for all nurses and Certified Nursing Assistants. Year I (2000) focused on documentation and basic assessments.

Year II, (2001) focused on the following:
*Physical Therapy- use of splints and braces
*Preventative measures
*Understanding the Braden Scale
*Skin assessments and measurements
*Documentation
*Infection Control issues
*Nutrition and Hydration.

Year 3, (2002) included the following curriculum:
*Ostomy Care
*Prevention of pressure ulcers in both high and low risk residents
*Positioning-use of splints, etc.
*Infection control
*Dietary involvement.

All of the sessions were jointly taught by an interdisciplinary team consisting of Dietary, Therapies, Nursing, and the Enterostomal Therapist. Nurses who are regarded as "leaders" in skin and wound care taught some of the sessions. All of the sessions were very well attended with excellent feedback from those that attended.

OUTCOMES AND COLLABORATIVE EFFORTS

One of the outcomes of the teaching day was the inception of the Skin Care Assessment Team (SKIN CATS). This interdisciplinary team targeted their efforts on planning and implementing new protocols. Over the past year and a half, they have successfully done the following:
* Developed skin assessment teams with a Team Captain responsible for assigning assessments for each unit.
*Revised the Braden scale to include contributing factors which would automatically place that resident at "High Risk". (Attachment 4)
*Developed a system whereby the Braden scale was completed quarterly with MDS assessments or as needed.
*Developed and revised the Wound Assessment and Treatment Record and flow sheet (attachment 5)
*Developed a Prevention Checklist
*Implemented a protocol for the nurse to include a certified Nursing Assistant when conducting skin assessments in order to capture a "teaching moment".
*Responsible for testing and recommending the purchase of pressure reduction equipment (mattresses and cushions, as well as positioning devices).

Our first evidence of success was the Prevalence study conducted in June of 2001. We had successfully reduced the prevalence rate for pressure ulcers to 9%!. This was due to the increased education and awareness of staff, as well as the diligence of the staff in identifying residents at risk and taking appropriate action and documenting clearly.

Hoping to improve on this even more, the interdisciplinary team began conducting chart reviews on residents with problematic skin integrity. These reviews resulted in changes in care plans, notification of physician, referral to Enterostomal Therapist or all of the above.

Our educational component expanded to include representatives from Nutritional supplement companies, and wound care product companies. They would not only demonstrate their products, but also allow us to trial them on specific residents. These trials, when successful, resulted in the purchase of pressure reduction items that have helped us to reduce our pressure ulcers even more.

During 2001, we revised and re-organized the skin assessment teams so as to expand the number of certified nursing assistants (CNA's) on the teams. By including the CNAs' in this process, we not only improved our residents' care, but also boosted the self-esteem of the CNAs'- who felt more a part of the nursing team than ever before. Skin Team rounds protocols were established and approved by the Medical Director of the facility. (Attachment 6) The interdisciplinary skin rounds were expanded to include Social Workers, Activities personnel, Infection control nurse, and the Medical Director, in addition to Nursing, Dietary and Rehabilitation Services.

In early 2002, the Enterostomal Therapist conducted a special inservice for the CNAs' on ostomy care- as the number of residents with ostomies had increased, and thus, the potential for skin breakdown increased as well. A Skin Care Formulary (Attachment 7) as well as a dressing Formulary were developed for use by all staff. Throughout the year new products were tested and purchased.

More success was evident when we conducted the prevalence study in June of 2002. The prevalence rate was down to 5%! We knew however, that even this was not good enough. The team began to review more closely who the residents were with pressure ulcers and how to prevent them. We are also tracking the pressure ulcers that are acquired while a resident is hospitalized and providing that feedback to the hospital as well as a component of their Quality Improvement program.

The Federal Quality Indicators are used as an integral component of our Quality Improvement initiative for Pressure Ulcers. Any residents who are scored as low risk for pressure ulcers, but develop one, have a chart review initiated immediately, to determine what opportunities we have to improve this.

As of November, 2002, our rate is at 3%! This improvement in resident quality is entirely due to the increased education, vigilance, and interdisciplinary teamwork involved.

Prevalence rate for Pressure Ulcers:

June 2000	22%
June 2001	9%
June 2002	5%

BARRIERS

Clearly, there were barriers to this success- one of the foremost being resources. The year 2000 and early 2001 were extremely challenging for recruitment and retention of long term care workers. Our turnover was in the 50+%. That meant an inordinate amount of temporary agency staff. The cost of hiring temporary staff and then educating them so as to provide consistency in our resident's care was challenging, at best. Another barrier is the rising cost of wound care supplies, dressings, and products. It is essential that these products be reviewed by an interdisciplinary team and used in a trial for residents at risk, if at all possible.

FUTURE GOALS

The presence of the Enterostomal Therapist on the team was certainly advantageous, if not critical to our success. Our goal would be to identify Nurses as potential candidates to mentor and coach into Enterostomal certification. In addition, we would like to begin a program for a "Skin Care Associate" at the Certified Nurse Aide level. This would be a career ladder opportunity and would allow us to expand our expertise on each unit. Our long term goal would be to purchase pressure reduction mattresses for the entire facility so as to even further reduce the opportunity for skin breakdown.

We will continue to explore opportunities to improve the quality of care for our residents and to further reduce the number of residents with pressure ulcers in our facility. In 2003 we will begin to track not only the prevalence, but the incidence of pressure ulcers as well.

We look forward to your comments and hopefully approval of this application.

Thank you for your consideration.

Sincerely,

Maria Motsavage

Maria Motsavage, RN, BSN, LNHA
President. CEO

PRESSURE ULCER TRACKING

Name	Stage	Area/Date	Measurement	Care Plan	Care Card	Prog. Note	24hr. Report	Diet Ref.	MD/FU	Recom/Ref

ATTACHMENT 1

Pressure Ulcer Monitoring Report

Court :_____

Date: October 2001

Name	Date	Stage	Area	Treatment	Inter	NP/MD	ICP	CC	Prog. Note	Diet	Resolution	Prev. RX	Risk

ATTACHMENT 2

ATTACHMENT 3

The High Risk Protocol

- Daily skin inspection, pay special attention to all pressure areas.
- Pressure reduction mattress and seating cushion if resident is out of bed to the chair.
- Turn and reposition every 2 hours (this includes those residents who are out of bed to the chair).
- Use assistive devices for transfers and repositioning (i.e. pull sheets or pads, lifts, slide board).
- Use pillows to keep bony prominences (i.e. knees, ankles) from direct contact with one another.
- Keep heels off bed - multipodus/heel lift boots, pillows under legs with heels hanging off end.
- Remove splints every shift to assess skin integrity.
- Limit time on bedpan or commode to 15 minutes.
- Contain fecal and urinary incontinence with underpads or briefs.
- Cleanse skin at time of soiling.
- Use protective skin care products after incontinence.
- Apply moisturizers to dry, flaking skin daily and as needed.
- Inspect, clean, and moisturize feet. No moisturizers between toes.

ATTACHMENT 3A

Non-Surgical Soft Tissue Wound Protocol

Pressure Ulcer, Chronic Wound, Arterial or Venous Lower Extremity Wounds

Partial Thickness Wound Protocol

Wound Discovered

Implement Preventative Checklist

Pressure reduction mattress (Iris/Theramax)

Document and Initiate:
- Document findings in progress note
- Start wound care sheet
- Place on 24 hr. report
- Care card reviewed and Update
- Care plan (IDCP) and Update
- Dietary referral
- Review Braden scale and recalculate if appropriate
- PT referral

Partial thickness wound includes stage I & II.(abrasion, skin tear, superfical, blister, shallow crater)

Cleanse wound with Normal Saline (NS)

A - Intact skin - Stage 1

Promote skin integrity by protecting intact skin

1 - Barrier ointment ie. Protective ointment, proshield
2 - Barrier wipe ie. 3M no sting barrier ointment
3 - Transparent Dressing

B - Partial thickness - Stage II

Select a dressing to keep the wound bed continuously moist, protect surrounding skin and control drainage:

1 - NS moistened gauze with BID - TID dressing changes or
2 - Transparent dressing (Tegaderm)* or
3 - Hydrocolloid dressing (Tegasorb)* or
4 - Foam dressing (Flexzan - thin, Allevyn - absorbent) or
5 - Vaseline gauze

*Do not use these products for lower extremity wounds - they are contraindicated in ischemia and uncontrolled diabetes and signs and symptoms of infection.

(If first product not effective after 1 week re-evaluate and change treatment if needed)

Notify physician of assessment and actions implemented

If a culture is indicated for signs of infection or physician order, cleanse wound with NS prior to obtaining the culture

Develop an individualized education plan for resident (when appropriate) and care giver including:
- Prevention
- Wound care

ATTACHMENT 3 B

Non-Surgical Soft Tissue Wound Protocol
Pressure Ulcer, Chronic Wound, Arterial or Venous Lower Extremity Wounds

Full Thickness Wound Protocol

Wound Discovered

Implement Preventative Checklist

Pressure reduction mattress (Iris/Theramax)

Document and Initiate:
- Document findings in progress note
- Start wound care sheet
- Place on 24 hr. report
- Care card reviewed and Update
- Care plan (IDCP) and Update
- Dietary referral
- Review Braden scale and recalculate if appropriate
- PT referral

Full thickness wound includes stage III, IV, and Necrotic tissue.
From dermal layer to subcutaneous and deeper (muscle or bone). Can include tunneling and undermining.
Necrotic tissue (yellow/brown)

Cleanse wound with Normal Saline (NS)

Pack wound with NS moistened and fluffed cotton gauze

Protect wound edges with a protective barrier (3m skin wipe or proshield barrier)

Apply cover/dry sterile dressing. Secure with tape or wrap and change TID.

Notify:
1 - Physician of Assessment
2 - Wound/Ostomy/Continence Nurse Specialist (WOCN)

Obtain further orders for treatment

If a culture is indicated for signs of infection or physician order, cleanse wound with NS prior to obtaining the culture

Develop an individualized education plan for resident (when appropriate) and care give including:
- Prevention
- Wound care

ATTACHMENT 4

United Health Services

Ideal Senior Living Center

Risk Assessment Tool

1. To be completed every 3 months and for any significant change.
2. If a resident has any contributing factors (see below), that will automatically place them at a high risk regardless of Braden Scale

BRADEN SCALE - For Predicting Pressure Sore Risk

Note: Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers	Date:						
RISK FACTOR	**SCORE/DESCRIPTION**						
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	**1. COMPLETELY LIMITED** Unresponsive (does not moan, flinch, or grasp) to painful stimuli due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body surfaces	**2. VERY LIMITED** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. **OR** has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body	**3. SLIGHTLY LIMITED** Responds well to verbal commands but cannot always communicate discomfort or need to be turned, **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. NO IMPAIRMENT** Responds well to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.			
MOISTURE Degree to which skin is exposed to moisture.	**1. CONSTANTLY MOIST** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. OFTEN MOIST** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. OCCASIONAL MOIST** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. RARELY MOIST** Skin is usually dry;;linen only requires changing at routine intervals.			
ACTIVITY Degree of physical activity	**1. BEDFAST** Confined to bed.	**2. CHAIR FAST** Ability to walk severely limited or nonexistent. Cannot bear own weight and/ or must be assisted into chair or wheelchair.	**3. WALKS OCCASIONALLY** Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. RARELY MOIST** Skin is usually dry; linen only requires changing at routine intervals.			
MOBILITY Ability to change and control body position	**1. COMPLETELY IMMOBILE** Des not make even slight changes in body or extremity position without assistance	**2. VERY LIMITED** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. SLIGHTLY LIMITED** Makes frequent throught slight changes in body or extremity position independently.	**4. NO LIMITATIONS** Makes major and frequent changes in position without assistance.			
NUTRITION Usual food intake pattern 1. NPO: Nothing by mouth, 2. IV: Intravenously 3. TPN: Total Parental Nutrition.	**1. VERY POOR** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, OR is NPO and/or maintained on clear liquids or IV for more than 5 days.	**2. PROBABLY INADEQUATE** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, OR receives less than optimum amount of liquid diet or tube feeding.	**3. ADEQUATE** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually takes a supplement if offered, OR is on a tube feeding of TPN regimen, which probably meets most of nutritional needs.	**4. EXCELLENT** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.			
FRICTION AND SHEAR	**1. PROBLEM** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. POTENTIAL PROBLEM** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. NO APPARENT PROBLEM** Moves in bed and in chair independently	Score			
TOTAL SCORE	TOTAL SCORE OF 16 OR LESS REPRESENTS HIGH RISK			Initials			

Contributing factors:

Place appropriate numbers in the Contributing Factors Box:

1. Albumin <3.0 last 30-days	4. Deiabetes/Hyperglycemia	7. PVD/Poor Circulation	10. Obesity	13. Terminal Condition
2. Dehydration	5. PreAlbumin <10	8. Edema	11. Pain Unrelieved	14. Restraints
3. History of Pressure ulcers	6. Contracted/Loss ROM	9. Incontinence Fecal	12. Renal Insufficiency	

Rev: 7/02

Risk Assessment Tool

1. To be completed every 3 months and for any significant change.
2. If a resident has any contributing factors (see below), that will automatically place them at a high risk regardless of Braden Scale

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ACTIVITY Degree of physical activity	**1. BEDFAST** Confined to bed.	**2. CHAIR FAST** Ability to walk severely limited or nonexistent. Cannot bear own weight and/ or must be assisted into chair or wheelchair.	**3. WALKS OCCASIONALLY** Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. RARELY MOIST** Skin is usually dry; linen only requires changing at routine intervals.			
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FRICTION AND SHEAR	**1. PROBLEM** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. POTENTIAL PROBLEM** Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. NO APPARENT PROBLEM** Moves in bed and in chair independently	Score			
TOTAL SCORE	TOTAL SCORE OF 16 OR LESS REPRESENTS HIGH RISK			Initials			

Contributing factors:

1. Albumin <3.0 last 30-days
2. Dehydration
3. History of Pressure ulcers
4. Deiabetes/Hyperglycemia
5. PreAlbumin <10
6. Contracted/Loss ROM
7. PVD/Poor Circulation
8. Edema
9. Incontinence Fecal
10. Obesity
11. Pain Unrelieved
12. Renal Insufficiency
13. Terminal Condition
14. Restraints

Place appropriate numbers in the Contributing Factors Box:

Rev: 7/02

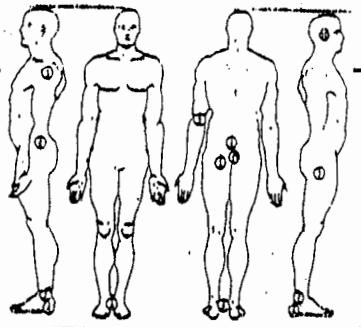
IDEAL SENIOR LIVING CENTER

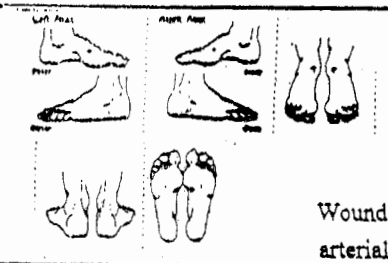
WOUND ASSESSMENT/TREATMENT RECORD

Location of wound (describe):

Use separate sheet for EACH wound.

Do not use for skin tears





Date of origin: _____

Treatment due: _____

Measurement due: _____

Weekly Documentation due: _____

Wound type: surgical ☐ Pressure ☐

arterial ☐ venous ☐ diabetic ☐ other ☐

Ordered Dressing							
	Pressure Ulcers Only Stage(1 - 4) All other wounds P(partial) or F (full) thickness	DATE					
		TIME					
	Size:	length					
		width					
		depth					
	Wound Base:	(pink / red %)					
		(yellow %)					
		(black / brown %)					
		(light pink, healing)					
	Wound Edges: undermining/tunneling						
	Drainage: 1. Write color 2. Odor: yes/no 3. Amount: small/ mod/lrg	Color					
		Odor					
		Amount					
	S/S infection: (Peri wound skin) Yes/No	Redness					
		Edema					
	Condition of surrounding skin: intact-(i); moist- (m); non-intact -(n)						
	Ordered dressing change completed (INITIALS)						

ATTACHMENT 5

IDEAL SENIOR LIVING CENTER

WOUND ASSESSMENT/TREATMENT RECORD

Location of wound (describe):

Use separate sheet for EACH wound.

Do not use for skin tears

_____

_____

Date of origin: _____

Treatment due: _____

Measurement due: _____

Weekly Documentation due: _____

Wound type: surgical ☐ Pressure ☐

arterial ☐ venous ☐ diabetic ☐ other ☐

Ordered Dressing							
	Pressure Ulcers Only Stage(1 - 4) All other wounds P(partial) or F (full) thickness	DATE					
		TIME					
	Size:	length					
		width					
		depth					
	Wound Base:	(pink / red %)					
		(yellow %)					
		(black / brown %)					
		(light pink, healing)					
	Wound Edges: undermining/tunneling						
	Drainage: 1. Write color 2. Odor: yes/no 3. Amount: small/ mod/lrg	Color					
		Odor					
		Amount					
	S/S infection: (Peri wound skin) Yes/No	Redness					
		Edema					
	Condition of surrounding skin: intact-(i); moist- (m); non-intact -(n)						
	Ordered dressing change completed (INITIALS)						

ATTACHMENT 6

United Health Services

Ideal Senior Living Center

SKIN TEAM ROUNDS PROTOCOL

PURPOSE:

To describe the method for the Skin Team to complete rounds within the skin management program.

The goals of skin rounds are to:

- Directly observe wound(s) for current status
- Evaluate progress of the current treatment(s)
- Make treatment adjustments as needed
- Education on wound status and treatment for resident/family and staff

PROCEDURE:

1. Each week the Skin Team visually inspects a select group of wounds within the facility. The center may decide which wounds are most appropriate to observe based on current clinical indicators within the center.

   Examples of various choices for Skin Team rounds viewing include
   - New or newly at-risk residents
   - All Stage IV and surgical wounds as well as any non-healing wounds
   - All State II, III and IV's and non-healing wounds
   - All facility-acquired wounds

   The need for Skin Team rounds may change as the program is implemented and wound care improves.

2. Circulate the list of wounds to be reviewed each week to the team participants and to the direct care providers so that these wounds can be undressed and ready for observation when the skin rounds occurs. The nurse (team leaders or treatment nurse) assigned to the resident can plan wound care around these observations so that the wound is disturbed a minimal amount and dressing supplies are not wasted.

3. The following members are to be involved in the Skin Team:
   * RCC
   * Activities
   * Social Work
   * Resident
   * Medical Director or designee
   * WOCN
   * DON or designee
   * Physical Therapist (only if therapy is providing wound care in the facility)
   * Registered Dietician

4. Designate one person on the team to document observations and follow up. (Such as obtaining suggested treatment changes.) Documentation of rounds is completed.

5. Each wound is observed and evaluated. Discussion of status and current treatment is conducted and staff and resident questions are answered.

   The team does not provided medical advice which is outside any professionals scope of practice. Any questions which require physician responses are directed to the physician.

6. The documentation corresponding to the wound being observed is reviewed and corrected if necessary. The team provides direction for any necessary follow up education for responsible staff members.

7. After the wound has been observed and discussed, the nurse assigned to the resident redresses the wound and positions the resident for comfort.

8. Any recommended treatment changes are carried out by the nurse assigned to the resident. It may be necessary in some cases to contact the attending physician to obtain new treatment orders.

9. Skin Team rounds should take no more than one hour, due to time constraints.

ATTACHMENT 7

I D E A L
SENIOR LIVING CENTER
A Member of the UHS Health Care System

Skin Care Product Formulary

A skincare product formulary is being established at ISLC skilled Nursing Facility in an attempt to select and use the most effective product for the stated purpose, to contain costs and to avoid the confusion of unnecessary duplication.

The Skincare Product Formulary

Prevention

1. 2 in 1 Shampoo and Bodywash (Convatec). Hair and body cleanser.
2. Nursing Care Personal Cleanser (Smith and Nephew). This is an effective no rinse cleanser that may be used safely on the entire body, primarily for peri area cleansing.
3. Nursing Care Protective Ointment (Smith and Nephew). This is a petroleum based protective barrier to use on those areas at risk of breakdown from moisture.
4. Cetaphil Cream - This is a water based, hypoallergenic (without perfumes or dyes) moisturizing cream used on areas of dry skin or prevent skin from becoming dry and flaky.
   - This product will be purchased for each resident as needed from Pharmacy Solutions . It is important to plan ahead for your resident and order it before they need it.

Treatment

5. Proshield Protective Barrier Ointment (Healthpoint). This is indicated for the treatment of redness and excoriation due to incontinence, for the treatment of partial thickness wounds in places where dressing adherence is difficult, and to protect the periwound skin when using other methods of wound management.
6. Triple Care Cream (Smith and Nephew). This is a zinc oxide (10%) product which is a protective barrier indicated for redness and excoriation due to incontinence and other areas affected by moisture and friction. It is an alternative to Proshield.